Open Enrollment 2014

State Employee Health Plan

Non-Medicare Options - Plans A, B, C
For Retiree/Direct Bill Members

Comparison Chart 1

***Cover photo is titled "Road into the Field" from the Postcards from Kansas collection by Dave Leiker.*

Kansas
Department of Health and Environment
Division of Health Care Finance

Monthly Premiums for Plan A, Superior Vision and Delta Dental Service

Coverage Choice	Monthly Medical Premiums			Monthly Superior Vision Premiums		Monthly Delta Dental Premiums
	Blue Cross Blue Shield of Kansas	Coventry	UnitedHealthcare	Superior Vision Basic Plan	Superior Vision Enhanced Plan	
1	$535.34	$595.80	$481.60	$4.36	$8.72	$28.97
2	$1,124.22	$1,251.22	$1,011.38	$8.72	$17.44	$65.18
3	$963.62	$1,072.46	$866.88	$7.86	$15.70	$72.42
4	$1,606.00	$1,787.42	$1,444.82	$12.20	$24.42	$115.88
B	$481.54	$535.92	$433.20	$6.54	$13.08	$28.97

Monthly Premiums for Plan B, Superior Vision and Delta Dental Service

Coverage Choice	Monthly Medical Premiums			Monthly Superior Vision Premiums		Monthly Delta Dental Premiums
	Blue Cross Blue Shield of Kansas	Coventry	UnitedHealthcare	Superior Vision Basic Plan	Superior Vision Enhanced Plan	
1	$501.08	$558.80	$452.24	$4.36	$8.72	$28.97
2	$1,052.26	$1,173.48	$949.72	$8.72	$17.44	$65.18
3	$901.94	$1,005.96	$814.16	$7.86	$15.70	$72.42
4	$1,503.22	$1,676.26	$1,356.76	$12.20	$24.42	$115.88
B	$450.72	$502.64	$406.80	$6.54	$13.08	$28.97

Monthly Premiums for Plan C, the High Deductible Health Plan WITHOUT HSA, Superior Vision and Delta Dental Service

Coverage Choice	Monthly Medical Premiums			Monthly Superior Vision Premiums		Monthly Delta Dental Premiums
	Blue Cross Blue Shield of Kansas	Coventry	UnitedHealthcare	Superior Vision Basic Plan	Superior Vision Enhanced Plan	
1	$346.22	$384.68	$310.90	$4.36	$8.72	$28.97
2	$775.58	$863.60	$698.00	$8.72	$17.44	$65.18
3	$647.44	$720.42	$582.86	$7.86	$15.70	$72.42
4	$1,159.92	$1,290.76	$1,043.56	$12.20	$24.42	$115.88
B	$342.44	$380.48	$307.50	$6.54	$13.08	$28.97

Coverage Choice Codes Key

1 - Member Only 2 - Member and Spouse Only 3 - Member and Child(ren) Only 4 - Member, Spouse and Child(ren) B - Medicare Member Only

IMPORTANT REMINDERS:

The premiums provided for vision and dental coverage above are separate from the premiums provided for the medical plans. Therefore, when calculating your total monthly premium, please be sure to add all three premium amounts, as applicable.

Health Plan Comparison Chart

	Plan A		Plan B		Plan C	
	Blue Cross and Blue Shield Coventry UnitedHealthcare		Blue Cross and Blue Shield Coventry UnitedHealthcare		Blue Cross and Blue Shield Coventry UnitedHealthcare	
	Network Providers	Non Network Providers	Network Providers	Non Network Providers	Network Providers	Non Network Providers
Basic Provisions						
Provider Choice	Freedom to use provider of choice, benefits based on plan description: coverage level based on provider network status					
Annual Deductible	$300 single/ $600 family	$500 single/ $1,500 family	$150 single/ $300 family	$500 single/ $1,500 family	$2,500 single / $5,000 family	$2,500 single / $5,000 family
Annual Coinsurance and Copay Max *(for all eligible expenses, unless otherwise noted)*	20% Coinsurance $1,700 single / $3,400 family	50% Coinsurance $3,650 single / $7,300 family	35% Coinsurance $3,500 single / $7,000 family	50% Coinsurance $3,650 single / $7,300 family	No Member Coinsurance	20% Coinsurance $1,500 single / $3,000 family
Out-of-Pocket Max	$2,000 single / $4,000 family	$4,150 single / $8,800 family	$3,650 single / $7,300 family	$4,150 single / $8,800 family	$2,500 single / $5,000 family	$4,000 single / $8,000 family
Lifetime Benefit Maximum	No limit	No limit	No limit	No limit	No limit	No limit
Amounts Above Plan Allowance	Provider to write off	Member responsibility	Provider to write off	Member responsibility	Provider to write off	Member responsibility
Preventive Care - *Limited to one visit or service per year unless otherwise noted. Review the benefit description for details on exact coverage.*						
Well Baby Exams - *includes newborn screenings & age appropriate office visits*	Covered In Full	Not covered	Covered In Full	Not covered	Covered In Full	Not covered
Well Child Exam - *includes office visit, age appropriate screenings and counseling*	Covered In Full	Not covered	Covered In Full	Not covered	Covered In Full	Not covered
Well Woman Exam - *includes office visit, age appropriate screenings, contraception & counseling*	Covered In Full	Not covered	Covered In Full	Not covered	Covered In Full	Not covered
Well Man Exam - *includes office visit, age appropriate screenings, contraception & counseling*	Covered In Full	Not covered	Covered In Full	Not covered	Covered In Full	Not covered

Prenatal Screenings and Counseling - *See benefit description for list of covered services*	Covered In Full	Not covered	Covered In Full	Not covered	Covered In Full	Not covered
Age Appropriate Bone Density Screening	Covered In Full	Not covered	Covered In Full	Not covered	Covered In Full	Not covered
Immunizations	Covered In Full	Covered in full to age 6 otherwise Deductible & 50% Coinsurance.	Covered In Full	Covered in full to age 6 otherwise Deductible & 50% Coinsurance.	Covered In Full	Covered in full to age 6 otherwise Deductible & 20% Coinsurance.
Mammography - *(not limited to one)*	Covered In Full	Deductible & 50% Coinsurance	Covered In Full	Deductible & 50% Coinsurance	Covered In Full	Deductible & 20% Coinsurance
Colonoscopy - *(not limited to one)*	Covered In Full	Not covered	Covered In Full	Not covered	Covered In Full	Not covered
Ultrasonography for Aortic Aneurysm - *limited to men ages 65 to 75 with history of tobacco use*	Covered In Full	Not covered	Covered In Full	Not covered	Covered In Full	Not covered
Routine Hearing Exam	Covered In Full	Not covered	Covered In Full	Not covered	Covered In Full	Not covered
Routine Vision Exam	Covered In Full	Not covered	Covered In Full	Not covered	Covered In Full	Not covered
Covered Services						
Inpatient Services	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 35% Coinsurance	Deductible & 50% Coinsurance	Deductible & 0% Coinsurance	Deductible & 20% Coinsurance
Physician Hospital Visits	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 35% Coinsurance	Deductible & 50% Coinsurance	Deductible & 0% Coinsurance	Deductible & 20% Coinsurance
Physician Office Visits Primary Care Provider	$25 Copay	Deductible & 50% Coinsurance	Adults: $20 Copay/ Dependent children 18 & under: $10 Copay	Deductible & 50% Coinsurance	Deductible & 0% Coinsurance	Deductible & 20% Coinsurance
Specialist	$45 Copay	Deductible & 50% Coinsurance	Adults: $40 Copay/ Dependent children 18 & under: $25 Copay	Deductible & 50% Coinsurance	Deductible & 0% Coinsurance	Deductible & 20% Coinsurance
Urgent care center	$50 Copay	Deductible & 50% Coinsurance	$50 Copay	Deductible & 50% Coinsurance	Deductible & 0% Coinsurance	Deductible & 20% Coinsurance
Outpatient Surgery	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 35% Coinsurance	Deductible & 50% Coinsurance	Deductible & 0% Coinsurance	Deductible & 20% Coinsurance

Emergency Room Visits	$100 Copay (waived if admitted) then Deductible & 20% Coinsurance	$100 Copay (waived if admitted) then Deductible & 20% Coinsurance	$100 Copay (waived if admitted) then Deductible & 35% Coinsurance	$100 Copay (waived if admitted) then Deductible & 35% Coinsurance	Deductible & 0% Coinsurance	Deductible & 0% Coinsurance
Other Outpatient Services	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 35% Coinsurance	Deductible & 50% Coinsurance	Deductible & 0% Coinsurance	Deductible & 20% Coinsurance
Ambulance Services	Deductible & 20% Coinsurance	Deductible & 20% Coinsurance	Deductible & 35% Coinsurance	Deductible & 35% Coinsurance	Deductible & 0% Coinsurance	Deductible & 0% Coinsurance
Major Diagnostic Tests	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 35% Coinsurance	Deductible & 50% Coinsurance	Deductible & 0% Coinsurance	Deductible & 20% Coinsurance
X-Ray and Laboratory	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 35% Coinsurance	Deductible & 50% Coinsurance	Deductible & 0% Coinsurance	Deductible & 20% Coinsurance
Rehabilitation Services: *(services limited to those medically necessary and appropriate: medical records must show continued improvement)*						
Inpatient facility	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 35% Coinsurance	Deductible & 50% Coinsurance	Deductible & 0% Coinsurance	Deductible & 20% Coinsurance
Outpatient facility	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 35% Coinsurance	Deductible & 50% Coinsurance	Deductible & 0% Coinsurance	Deductible & 20% Coinsurance
Office based	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 35% Coinsurance	Deductible & 50% Coinsurance	Deductible & 0% Coinsurance	Deductible & 20% Coinsurance
Durable Medical Equipment	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance: limited to $5,000 per person per year	Deductible & 35% Coinsurance	Deductible & 50% Coinsurance: limited to $5,000 per person per year	Deductible & 0% Coinsurance	Deductible & 20% Coinsurance: limited to $5,000 per person per year
Allergy Testing	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 35% Coinsurance	Deductible & 50% Coinsurance	Deductible & 0% Coinsurance	Deductible & 20% Coinsurance
Antigen Administration: *desensitization/treatment; allergy shots*	Covered in full	Deductible & 50% Coinsurance	Covered in full	Deductible & 50% Coinsurance	Covered in full	Deductible & 20% Coinsurance
Autism Services	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 35% Coinsurance	Deductible & 50% Coinsurance	Deductible & 0% Coinsurance	Deductible & 20% Coinsurance
Manipulation Therapies	Deductible & 20% Coinsurance: limited to 30 visits per year	Deductible & 50% Coinsurance: limited to 30 visits per year	Deductible & 35% Coinsurance: limited to 30 visits per year	Deductible & 50% Coinsurance: limited to 30 visits per year	Deductible & 0% Coinsurance: limited to 30 visits per year	Deductible & 20% Coinsurance: limited to 30 visits per year
Licensed Dietitian Consultation: *for medical management of a documented disease*	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 35% Coinsurance	Deductible & 50% Coinsurance	Deductible & 0% Coinsurance	Deductible & 20% Coinsurance

Hospice - *services must be pre-approved by health plan; limited to six months*	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance	Deductible & 35% Coinsurance	Deductible & 50% Coinsurance	Deductible & 0% Coinsurance	Deductible & 20% Coinsurance
Preferred Lab Benefit	*The Preferred Lab Benefit program is included when you choose either Plan A or Plan B as a way to save you money on outpatient laboratory tests. When you use a collection site of either Quest Diagnostics (state and nationwide) or Stormont Vail Health Care (8 locations in NE Kansas) for outpatient lab work covered by Plan A or Plan B, the cost will be covered at 100 percent of the negotiated amount with no deductible, copayment or coinsurance. Eligible services will be identified by your health plan and paid in full.*					
Mental Health						
Mental Illness & Drug or Alcohol Treatment	Same Coverage as Medical					

The comparison chart is NOT the governing document.
Members need to refer to each Provider's Benefit Description posted at ***www.kdheks.gov/hcf/sehp/BenefitDescriptions.htm***

Caremark Prescription Drug Benefits for Plan A and Plan B

Tier	Type of Prescription Medication	You Pay	Your Out-of-Pocket Maximum
Tier 1	**Generic Drugs**	20% Coinsurance	There is an Out of Pocket (OOP) maximum of $2,750 for single and $5,500 for family per year.
Tier 2	**Preferred Brand Name Drugs**	35% Coinsurance	
Tier 3	**Special Case Medications**	Maximum of $75 per standard unit of therapy	
Tier 4	**Non Preferred Brand Name Drugs**	60% Coinsurance	
Tier 5	**Discount Tier Medications**	100% Coinsurance	N/A
Tier 6	**Anticancer Oral Medications**	25% Coinsurance to a maximum of $75 per standard unit of therapy	Separate Coinsurance maximum of $750 per member per year
Value Based	**Diabetes**	**Generic** — 10% to a max of $10/30-days **Preferred Brand** — 20% to a max of $20/30-days	Applies to the Out of Pocket maximum (See above)
Value Based	**Asthma**	**Generic** — 10% to a max of $10/30-days **Preferred Brand** — 20% to a max of $20/30-days	Applies to the Out of Pocket maximum (See above)

Preferred Drug list, specialty drug list and discount tier list available on the web at ***www2.caremark.com/kse***

Caremark Prescription Drug Benefits for Plan C

Tiers 1 (Generic)**, 2** (Preferred Brand Name)**, 3** (Non Preferred Brand Name) **and 4** (Anticancer Oral Medications) **are subject to the deductible of $2,500 single / $5,000 family - no coinsurance. You / Your Family will be responsible for 100% of the cost of prescription drugs until the deductible of $2,500 single / $5,000 Family, is satisfied.**

Discount Tier Drugs are not covered and do not count toward the Health Plan Deductible.

Delta Dental Benefits			
	Delta Dental PPO Network Provider	**Delta Dental Premier Network Provider**	**Non Network* Provider**
Annual Benefit Maximum	$1,700 per member		
Lifetime Orthodontic Benefit	50% Coinsurance to a maximum of $1,000 per member		
Implant Coverage (Benefit subject to Annual Benefit Maximum above)	50% Coinsurance		
DEDUCTIBLE			
Diagnostic and Preventive Services	No Deductible		
Basic Restorative Services	$50 per person per Plan year Not to exceed an annual family deductible of $150		
Major Restorative Services			
COINSURANCE			
BASIC BENEFIT **Applies when you have NOT had at least one routine prophylaxis (cleaning) and/or preventive oral exam in prior 12 months**			
Diagnostic and Preventive Services	Allowed Amount covered in full by the Plan*		
Basic Restorative Services	50%	50%	50%
Major Restorative Services	50%	50%	50%
ENHANCED BENEFIT **Applies when you have had at least one routine prophylaxis (cleaning) and/or preventive oral exam in prior 12 months**			
Diagnostic and Preventive Services	Allowed Amount covered in full by the Plan*		
Basic Restorative Services	20%	40%	40%
Major Restorative Services	50%	50%	50%

**Services by Non Network providers are subject to the Allowed Amount including the Maximum Plan Allowance for Non Network Providers. Any amounts in excess of the Allowed Amount will be the member's responsibility.*

Your coinsurance will increase for Basic Restorative Services when you have not had a routine prophylaxis (cleaning) and/or preventive oral exam in the preceding twelve (12) month period. Ninety (90) days following receipt of a qualifying prophylaxis (cleaning) or preventive oral exam, you will qualify for the Enhanced Benefit Level. The Plan reserves the right to determine what services will qualify as meeting the definition of a routine prophylaxis (cleaning) and preventive oral exam. Routine prophylaxis (cleanings) and preventive exams shall not include any services provided on an emergency basis or for treatment of an injury to the teeth.

Superior Vision Benefits			
Service or Item	**Basic Plan: Network**	**Enhanced Plan: Network**	**Both Plans: Non Network**
Eye Exams: Subject to $50 Copayment			
• Eye exam, M.D.	Covered in full after Copayment	Covered in full after Copayment	Up to $38
• Eye exam, O.D.	Covered in full after Copayment	Covered in full after Copayment	Up to $38
Eyeglasses: Subject to $25 materials Copayment			
• Frame	Up to $100 retail*	Up to $150 retail*	Basic Up to $45 Enhanced Up to $78
• Single vision lenses, pair	Covered in full after Copayment	Covered in full after Copayment	Up to $31
• Bifocal lenses, pair	Covered in full after Copayment	Covered in full after Copayment	Up to $51
• Trifocal lenses, pair	Covered in full after Copayment	Covered in full after Copayment	Up to $64
• Lenticular lenses, pair	Covered in full after Copayment	Covered in full after Copayment	Up to $80
• Progressive lenses, pair	Not covered	Covered up to $165*	Not covered
• High index lenses, pair**	Not covered	Covered up to $116*	Not covered
• Polycarbonate lenses, pair**	Not covered	Covered up to $116*	Not covered
• Scratch coat	Not covered	Covered in full	Not covered
• UV coat	Not covered	Covered in full	Not covered
Contact Lenses: Not subject to materials Copayment			
• When medically necessary	Covered in full	Covered in full	Up to $210 retail*
• Elective/cosmetic retail	Up to $150 retail*	Up to $150 retail*	Up to $105 retail*
Contact Lens Exam (fitting fee) ($35 Copayment)			
• Specialty contacts***	Up to $50*	Up to $50*	Not Covered
• Standard Contacts****	Not Covered	Covered in full	Not Covered

**You are responsible for any charges above the allowance.*

*** You may only be covered for one pair of high index lenses or polycarbonate lenses under the Enhanced Plan (up to the allowance provided above).*

**** Specialty contacts are for new contact lens wearers or patients who wear toric, gas permeable or multi-focal lenses; includes two follow-up visits within three months of initial fitting.*

***** Standard contacts are for existing contact lens wearers of disposable, daily wear or extended lenses; includes two follow-up visits within three months of initial fitting.*

Notes:

- Members can use either the contact lens benefit or the eyeglass benefit, but not both in the same plan year.
- For non network claims, copayment amounts are deducted from the benefit allowance at the time of reimbursement.
- Covered lenses are standard glass or plastic (CR-39), clear.